APPLICATION FOR ADMISSION TO THE

ARKANSAS VETERANS HOME

4701 WEST CHARLES BUSSEY

LITTLE ROCK, AR 72204

PHONE 501-296-1885 FAX 501-296-1888

(Please type or print all information)

Full Name:_____SS#:_____

Address:_____ State:_____ Zip:_____

Phone # :(_____)-_____ Age:_____ DOB:_____

Sex: M F Marital Status: M D S Year of Marriage:_____

Spouse Name:_____ Phone #: (____)-_____

Address:_____ State:_____ Zip:_____

Dependent Children: Yes No

Military Information:

More than one branch of service? Yes No **More than one enlistment?** Yes No

Branch of service _____ **Type of discharge**_____

_____ _____

Date of enlistment_____ **Discharge Date** _____

_____ _____

Serial #_____ **Claim pending?** Yes No

Claim #_____ **DD-214?** Yes No

Separation document? Yes No **Service connected**_____% **POW?** Yes No

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Brief personal profile: Smoker? Yes No **Use of other tobacco?** Yes No

Able to transfer from wheelchair unassisted? Yes No **Ambulatory?** Yes No

Special needs diet associated with religion? Yes No **Legally Blind?** Yes No

Financial Information: Circle One: Compensation NSC Pension SS

Military Retirement Civil Service Other source_____

Direct Deposit? Yes No **Payee assignment?** Yes No

Court appointed guardian? Yes No **Personal Representative?** Yes No

Medical information: Enrolled in VA Health Systems? Yes No
If yes, which hospital clinics? Little Rock North Little Rock Fayetteville Memphis Other:_____

Non VA physician? Yes No If yes, Name:_____

Address:_____

Resided in long term care facility or nursing home prior to this application? Yes No
If yes, Place and address:_____

Date of last hospitalization:_____ Place:_____

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The Arkansas Veterans Home is a health care facility that operates under the jurisdiction of federal and state guidelines established by the Veterans Healthcare Administration and Department of Human Services, Office of Long Term Care. No veteran meeting the eligibility requirements of this facility shall be discriminated against due to race, color, religion, creed, gender, or national origin.

Families are encouraged to be involved in the resident's health care by taking them to clinic appointments, attending care plan meetings and visiting with AVH medical staff. Families are also encouraged to visit as often as necessary to maintain a good relationship with the resident. Visiting areas are provided and meals are available for a small fee. Visiting in the rooms is discouraged due to the disturbance to the roommate.

No resident is kept against his/her will. AVH has no method restraining any resident desiring to leave against medical advice. In case of residents under guardianship or court order leaving against advice, responsible parties will be notified.

Residents who fail to adjust to group living, are not compliant with rules or prescribed medical therapies, or fail to pay the monthly fee will be discharged. Residents who fail to manage their finances properly will be recommended for a payee or guardianship.

Payment for services is expected at admission and will be based on accessible funds, verified by the current bank statement of the resident. Thereafter, payment is expected by the 10th of each month. Increased pension will be applied for those qualifying. Residents are expected to have their funds direct deposited. It is not necessary to maintain spending money in AVH patients' accounts, but it does make cash more expediently accessible than waiting for a trip to the bank. Residents are discouraged from having more than $15.00 in cash on them; larger amounts can be taken when going out shopping. Lost cash cannot be replaced.

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I desire to live at the Veterans Home. If admitted, I agree to abide by the published rules established to maintain order and harmony among all the residents and those set out by the professional team to safeguard my health, safety and well being.
Signed_____ Date_____

Guardian or personal representative signature_____

APPLICANT INTAKE DATA SHEET (ATTACH TO APPLICATION FOR ADMIN FILE)

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Name_____ SS#_____ Date_____

Source of income, per month: NCS Pension $_____ Compensation $_____

Social Security $_____ Interest $_____ Retirement $_____

Other $_____ Total monthly income $_____

Savings: Yes No **Checking:** Yes No (Retain copies of last statements if unable to pay in full)

ATM Card: Yes No **Bank Debit Card:** Yes No **Credit Card:** Yes No

Party(ies) with access to accounts and/or card: _____
Name or "payee" "guardian" "POA" "designate" etc.

Relationship:_____ Phone:_____

Direct Deposit to:_____ Address:_____
Bank Name

POD designated on account: Yes No

Debts owed? Amount_____ To whom_____

Monthly obligations_____ _____ _____
Life insurance, burial policy, etc.

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Legal Data:

Name of payee:_____ **Phone:**_____

Address:_____ **Zip:**_____

Name of Guardian:_____ **Phone:**_____
Person ____ Estate ____ Person & Estate ____ (Retain copy of letters)

Address:_____ **Zip:**_____

Power of Attorney designate:_____ **Phone:**_____

Address:_____ **Zip**:_____

Advance Directive:

Healthcare proxy Yes No **Location:**_____

Living Will Yes No **Location:**_____

SOCIAL SERVICE DEPARTMENT

RESIDENT UPDATE FORM

Please fill out the following information and return to your social workers' office. This information is needed to insure that all files are updated and current.

Resident Name: _____ SS#: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____

Work Phone Number: _____

*** ADDITIONAL NAMES AND NUMBERS MAY BE ADDED IF NECESSARY.**

_____ _____

_____ _____

_____ _____

_____ _____